Members

Rep. William Crawford, Chairperson
Rep. Charlie Brown
Rep. Clyde Kersey
Rep. David Frizzell
Rep. Timothy Brown
Sen. Patricia Miller
Sen. Robert Meeks
Sen. Connie Lawson
Sen. Billie Breaux
Sen. Rose Ann Antich-Carr
Sen. Vi Simpson

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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Authority: IC 2-5-26

MEETING MINUTES[1]

Meeting Date:	**June 14, 2004**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Clyde Kersey; Sen. Patricia Miller; Sen. Robert Meeks; Sen. Billie Breaux.**

Members Absent: **Rep. David Frizzell; Rep. Timothy Brown; Sen. Connie Lawson; Sen. Rose Ann Antich-Carr; Sen. Vi Simpson; Sen. Gary Dillon.**

Rep. William Crawford, Chair, called the first meeting of the Select Joint Commission on Medicaid Oversight to order at 10:10 a.m.

Charge of the Commission

After members were introduced, staff presented the charge of the Commission (See Exhibit 1.) The charge consists of the ongoing statutory charge contained within IC 2-5-26-8 and the charge added by HEA 1320-2004 to study the effects of the repeal of continuous eligibility for children under the Indiana Medicaid Program and the Children's Health Insurance Program (CHIP). A report on the second charge is required to be submitted to the Legislative Council by November 1, 2004.

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Medicaid Budget Update -

Ms. Melanie Bella, Assistant Secretary for the Office of Medicaid Policy and Planning (OMPP), updated the Commission on the status of the Medicaid budget, reporting that the state would likely finish the fiscal year with a deficit in the Medicaid budget of $21.7 M. This deficit would have been much greater without the "temporary fiscal relief" provided by the federal government. This fiscal relief consists of an additional 2.59% in federal matching assistance percentage (FMAP) and is expected to end June 30. However, Ms. Bella added that although the near-term deficit was nearly covered, the estimated shortfall going into FY 2006 will be about $122.4 M.

Ms. Bella stated that enrollment continues to grow, especially in the disabled population. Total expected enrollment at the end of this biennium is 842,000 (including CHIP), compared with 760,000 in the previous year and about 742,000 in 2002. OMPP is currently exploring reasons why the disabled population is growing at a rate of 7%.

Ms. Bella added that the enrollment in Medicaid nationally is about 52 million people, while the enrollment for Medicare is only about 40 million. She indicated that because of this and the resulting expenditures in the program, there is a growing need for federal Medicaid reform in addition to Medicare reform.

In response to questions from the members, Ms. Bella indicated that she would provide additional information at the next meeting on cost savings from the implementation of mandatory managed care. In response to members' requests for the information given to the State Budget Committee, Ms. Bella indicated that the information, which would include Medicaid enrollment figures, would be provided to the Commission in writing.

EDS Update -

Mr. Rick Shaffer, Senior Vice President of EDS, introduced Mr. Dennis Vaughan, Executive Director of the Indiana Health Coverage Program for EDS, to provide the Commission with an update of the Indiana Medicaid Program statistics. Mr. Vaughan provided members with a two-page handout describing various statistics, including Medicaid dollars paid; number of claims paid, denied, and adjusted; number of providers enrolled and participating; recipients enrolled; Medicaid spending by service; claim volume; call center statistics; systems availability statistics; provider statistics; publications; and Medicaid highlights regarding HIPAA status and program enhancements. (See Exhibit 2.)

Mr. Vaughan, responding to questions from members, stated that he would try to have the following information by the next meeting: additional information on provider specialties losing enrollment; underserved areas in Indiana and geographical differences with respect to brand name and generic drugs; and the provider groups that may have higher-than-average claim denials. Members also requested that information be provided that better represented the denial of payments for services that had actually been provided.

Ms. Bella indicated that she would provide the Commission with additional information on the cost and provisions of the Pharmacy Benefit Manager (PBM) contract and how decisions by the PBM are made. The Commission also requested statistics on the number of prior authorization calls for both early refill on prescriptions and approval of drugs not on the preferred drug list.

Additional information requested by the Commission includes the status of working with providers on reporting requirements on drug costs and potential cuts in the Medicaid program if the state continues with its fiscal crisis (for October meeting).

Nursing Facility Assessment -

Ms. Bella, OMPP, provided members with an update on the progress of Indiana's waiver request to establish a nursing facility assessment. (See Exhibit 3.) Ms. Bella discussed the legislative origins of the assessment, as well as the federal regulations involving provider taxes. To receive a waiver, a provider tax must be generally redistributive and providers cannot be held harmless. She stated that two states, Oregon and North Carolina, have received approval from the federal Center for Medicare and Medicaid Services (CMS) for similar waivers, although those assessment programs appear to involve fewer exclusions and exemptions of facilities. Indiana submitted its waiver in September 2003 with a requested effective date of July 1, 2003, but in March 2003, CMS notified OMPP that the waiver violates the hold harmless provision.

OMPP, working with the nursing facility associations, submitted a second request in May 2004. Initial feedback from CMS indicates that the second request may not yet satisfy the hold harmless requirement. OMPP is continuing to work with the three nursing facility associations to develop an alternative that will meet with CMS approval.

Ms. Bella was asked to provide a side-by-side comparison of the features of the Oregon, North Carolina, and Indiana waiver requests, along with the reasons why other states are getting approval for their waivers and Indiana isn't. Members also requested a list of nursing facilities which may have a net loss from the proposed assessment.

Overview of Medicaid Waivers -

Ms. Bella provided members with an overview of the Medicaid waiver process. (See Exhibit 4.) Ms. Bella explained that the Medicaid and CHIP programs are governed by federal laws and regulations, and states who wish to operate differently must seek a waiver of those laws and regulations. She indicated that there are three principal types of waivers.

The 1115 Research and Demonstration waiver is based on the authority of the Secretary of Health and Human Services to "authorize experimental, pilot, or demonstration projects which... are likely to assist in promoting the objectives" of the Medicaid program.

The 1915(b) Freedom of Choice waiver is designed for the purpose of waiving the statewideness, comparability, and freedom of choice provisions of the federal Medicaid statute. The 1915(b) waiver is used to operate managed care programs, such as the Hoosier Healthwise and Medicaid Select managed care programs in Indiana.

The 1915(c) Home- and Community-Based Services waiver is for the purpose of allowing states to provide Medicaid services in the home and in the community, rather than only in institutional settings. Indiana has eight such waivers: Developmentally Disabled, Autism, Support Services, Aged and Disabled, Assisted Living, Medically Fragile Children, Traumatic Brain Injury, and Children with Serious Emotional Disturbances.

Waivers must be shown to be cost neutral in the aggregate, and are limited in number of available funded slots.

In response to a question as to whether the state could get a waiver to allow the dollar limit on spend-down to be waived if the recipient were at risk of institutionalization, Ms. Bella stated that in order to do that, the income eligibility standards for the aged, blind, and disabled categories would have to be changed.

Update on the Spend-Down Issue -

Ms. Bella described for the Commission the spend-down process for Medicaid and the status of the issue regarding the counting of third-party payments as part of a recipient's spend-down obligation. (See Exhibit 5.) In the aged, blind, and disabled Medicaid categories, a recipient can still become eligible for Medicaid even if the individual's countable income is greater than the eligibility threshold, if the individual can demonstrate that medical expenses have been incurred in the amount that the individual's income is in excess of the eligibility threshold.

Current and past policy has considered the entire amount of incurred medical expenses as counting toward the spend-down amount. According to OMPP, including medical expenses that are paid or reimbursed from a third party as part of the spend-down obligation, such as insurance or Medicare, is in violation of federal regulations. Ms. Bella described some of the provisions of the rule which OMPP has proposed to bring Indiana into compliance with federal regulations. The anticipated effective date of the rule is November 1, 2004. However, an amended Complaint has been filed by the plaintiffs in the spend-down lawsuit asking for a preliminary injunction hearing in September.

Introduction of the Continuous Eligibility Study Topic -

HEA 1320-2004 mandates the Commission to study the effects of the repeal of continuous eligibility for children under the Indiana Medicaid Program and CHIP on certain aspects of government, the economy, children, and families. Ms. Bella provided members with an overview of continuous eligibility, which guaranteed that children were eligible for Medicaid or CHIP coverage for 12 months even if the family's income increased or other eligibility circumstances changed. (See Exhibit 6.)

Ms. Bella explained that 12-month continuous eligibility began in September 1998, but was discontinued in July 2002. Families are now required to report changes affecting eligibility, and children may lose coverage if the reported income exceeds the program limits.

Ms. Bella noted that estimation of the impact of repeal of continuous eligibility will be difficult to determine due to the manner in which data is coded in the Indiana Client Eligibility System (ICES). Children may lose coverage for a variety of reasons, most of which are not separately identified in the system.

Public Testimony -

Rep. Crawford opened the meeting to public testimony on any of the issues discussed.

John Cardwell stated that he was eager to hear answers on some of the questions raised in this meeting, especially regarding issues involving the implementation of SEA 493-2003.

Next Meeting Date

Rep. Crawford announced that the next two meetings would likely be held in August and October. Final dates would be established after consultation with the members.

There being no further business, the meeting was adjourned at about 11:45 a.m.